IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

ERIC JEFFRIES, Plaintiff
v. Case No. C-1-02-351
CENTRE LIFE INSURANCE CO. et als., Defendants

DEPOSITION OF: MITCHELL I. CLIONSKY

taken before Jessica R. Stasio, Notary Public-Stenographer, pursuant to Rule 30 of the Rules of Civil Procedure, at the offices of ACCURATE COURT REPORTING, 1500 Main Street, Springfield, Massachusetts on September 23, 2003.

Appearances: (see page 2)

Jessica R. Stasio
Registered Professional Reporter

APPEARANCES

FOR THE PLAINTIFF:
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FOR THE DEFENDANTS:
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BY: WILLIAM R. ELLIS, ESQ.

IN ATTENDANCE: Carrie Barnes, Esq.

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MITCHELL I. CLIONSKY, Deponent, having first been duly sworn, deposes and states as follows:

DIRECT EXAMINATION BY MR. ROBERTS:

Q. Good morning, Dr. Clionsky. My name is Mike Roberts. I represent Eric Jeffries. Could you kindly state and spell your name for the record as well as your residential address?

A. Sure. It's Mitchell Clionsky. C-L-I-O-N-S-K-Y, and my office address is 155 Maple Street, suite 203, Springfield, Massachusetts. 01105.

Q. What is your residence address?

A. Is that necessary?

Q. Yes.

A. I prefer to not have something that's publicly --

MR. ELLIS: That's your choice.

MR. ROBERTS: We will seal this.

A. I'm a resident of Hampden County.

Q. I need your residence address in the event I need to subpoena you in the future. You've been identified as an expert in a lawsuit by Mr. Ellis.

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The need may arise for me to have you served with a subpoena in the future, and for that purpose I need your residence address.

MR. ELLIS: I will accept service for Dr. Clionsky of any subpoena, or it can be issued at his office.

Q. (by Mr. Roberts) I will need your residence address, sir.

A. I get served all of my subpoenas at the office. It's a standard part of business practice, and I don't intend to give you my home address. My home address is unlisted. My telephone number is unlisted. I do not wish to be -- have them listed in this day and age unless you want to put this under seal.

Q. I will do that.

A. Okay. Then you can have it.

Q. Okay. What is it?

A. (Answer was stricken)

MR. ROBERTS: Let's just strike that from the record. I mean I could just write it down off the record, so let's strike that last response from the record, and if you could just repeat it for me to make sure I have it

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written down correctly in my notes. We'll go off the record.

(Discussion off the record)

Q. (by Mr. Roberts) Sir, you've been engaged from time to time to review materials relating to Eric Jeffries; is that right?

A. Yes.

Q. And have you had the opportunity to review reports prepared by a Paula Shear and a Jim Hawkins?

A. To the best of my knowledge, no.

MR. ROBERTS: Okay. Why don't we go back off the record.

(Discussion off the record)

MR. ROBERTS: Let's go back on the record.

The report, the expert report deadline in the case for the Plaintiff was August 15th. On August 15th I provided the reports of Dr. Shear and Dr. Hawkins to Mr. Ellis. The expert report deadline for Mr. Ellis was August 30th. On August 30th of 2003 he identified Dr. Clionsky as an expert in the case. The fact discovery witness deadline was August 31st. The expert discovery deadline is October 15th.

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I'm here today for the purpose of examining Dr. Clionsky, the identified expert, as to his opinions in the case. I have presented him -- he should have been presented with copies of my expert reports before he was identified as an expert. If he wasn't, he wasn't. And if he wasn't given them before today, he wasn't. But I intend to proceed in this deposition by taking a break, suspending the deposition now, having Dr. Clionsky review these materials and ask him questions. If when I ask him questions, because he wasn't given the reports before today and feels inclined not to answer the questions because he hasn't had satisfactory time to review the material, then he can say that at that time. But the way we're going to proceed is that Dr. Clionsky takes as much time as he desires to review these reports, we'll go back on the record when he instructs me that he's done that, and we're going to ask him questions. That's what we are going to do. This is my opportunity. I spent a lot of money to come to Massachusetts to take the deposition of an expert, and that is what

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we are going to do.

MR. ELLIS: In response, if the Doctor wishes to do that, I'm not going to tell him that he shouldn't. I will point out that these reports were not sent to Dr. Clionsky for his comment and therefore will not be part of his comments at the trial of this case to my knowledge. And he's not the only expert who's been named. One of our experts has reviewed these reports, it just doesn't happen to be Dr. Clionsky. Dr. Clionsky is prepared to testify about those things he has done in this claim file on behalf of DMS, and I don't believe it's proper for counsel for the Plaintiff to ask his opinions on matters outside the scope of his review.

MR. ROBERTS: Let's go. We're going to go off the record, Dr. Clionsky's going to be asked to review these. If he refuses to review them, then the deposition will be suspended as several others were in this case because of Mr. Ellis' interference, and I will require that the court order that the Defendants make Dr. Clionsky available

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example, or in the supraspinal fluid over multiple times in different places in the brain so that you can image the brain, for example, one day and there is a plaque in one area or two areas, and then six months later there may be nothing going on from a neurologically radioneurological approach. Six months after that, consistent with changes and certain symptoms, you might find that there is plaque in the visual cortex that didn't appear before. One thing about people with MS is that they do experience changes in their cognitive and emotional functioning reflective of the changes that are going on neurologically. And what is interesting, I guess, is that you can image these and be able to see where they are taking place at various times and correlate them with what is going on clinically.

Q. Could I direct your attention to page seven, paragraph number four under the word Diagnosis?

A. Yes.

Q. She, Dr. Shear, suggests there that Dr. Hartings has concluded that Mr. Jeffries suffers from Cognitive Disorder. Is that your understanding

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of what Dr. Hartings concluded?

A. Yes.

Q. The next paragraph starts General Comments. Dr. Shear talks generally about the use of the DSM IV materials. You agree with what she is saying there?

A. About what?

Q. The somatization disorder and obsessive-compulsive personality disorder are both specialized terms, it's as she describes it there?

A. That they are both specialized terms that are part of the -- listed in the DSM, certainly.

Q. The current version of the diagnostic handbook is DSM-IV-TR; right?

A. I am not familiar with the TR. I am still using the IV. I must be behind the times. Hopefully they haven't changed too many diagnoses in the last couple months.

Q. The last three lines of that paragraph she says for each mental disorder in the DSM, the clinician is provided with explicit criteria that the patient must meet before diagnosis is assigned. Is that correct?

A. No.

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Q. What's incorrect about that?

A. The DSM is a consensus document. Take a group of fifteen people who are on the committee to establish the criteria for a certain diagnosis, let's say it's Attention Deficit Hyperactivity Disorder just for the sake of argument. They will then have the input based on what they're reading as knowledgeable parties or experts in the field about what are the conditions, what are the symptoms, what are the standards that they use to try to determine how to best design this diagnostic category. The fact that there are at least four, because we've gone up through the various versions of the DSM, this TR is, of course, the newest one, but there has been DSM IV, DSM III, DSM III-R, all revisions, all attempts at better understanding psychopathology. With each revision there are things that are added, things that are taken away largely based on what the consensus is at that point as to how things work. The practicing clinician rarely sees pure form cases of any disorder. Usually they are set up in a cookbook fashion. You know, column A, you need two out of these. Column B, you need three out of these. Column C, you need one out of these.

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Sometimes you are fortunate enough as a clinician to get a case that meets all of those criteria in each case, and you can say with at least a greater sense of certainty if -- and confidence, if not truth, because I am not sure it actually is truth, but a greater sense of certainty that what you have is a true diagnosis here. I can tell you that different people looking at the same patient can legitimately come up with different diagnoses based on their reading of those symptoms and what falls into which category. In the case of ADHD, you have a symptom where -- you have two classes of symptoms. One's an inattention cluster where there is nine symptoms; the other is a hyperactivity/impulsive cluster where there is also nine symptoms. In order to make a diagnosis of a child, you need six out of the nine in one or the other or both categories. Now, you also get people like Russel Barkley, who's one of the preeminent experts in this area who says that in adults often times the disorder ameliorates a bit, it becomes less severe, and then you only need four or five. So the issues of prevalence, the issues of date of onset, the course, all of these various factors that go in, as well as the specifics of how

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many you need in each category are meant as a source of guidance. They are not made in a way that allows you to say, well, this can't be the diagnosis because there are only four out of the five here. This can't be the diagnosis because there is only two out of the three here. Because what happens is you have this huge wastebasket of leftovers where it doesn't meet any diagnosis. That doesn't mean the person is psychologically healthy, it just means you didn't come up with enough specific symptoms. And some of these symptoms, for example, sexual dysfunction, the person does not complain about symptoms of sexual dysfunction. Okay, well, does that mean that they don't have this disorder or they simply don't want to talk about that? I don't know. But what your job is as a clinician is to try to best understand, hopefully, for the job of helping somebody and treating them as to what's going on so that you can use that diagnosis to understand the disorder. That's the whole purpose of diagnosis is to understand.

So, when we get back to do I agree with that statement, to sort of draw this full circle, no, I don't believe that people have to meet

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specific numbers of criteria in order for the diagnosis to best fit.

Q. The DSM IV, though, does talk in mandatory terms you must have the following. When I say mandatory terms, I mean must, you must have, you know, one, two, and three. Not and/or. You understand that the DSM talks in mandatory terms?

A. To tell you the truth, I have not read the specific language of the DSM in this category in terms of the musts and shoulds.

Q. Okay.

A. It very well might. I'm telling you that as a clinician that does not mean that those things are always present for someone to have a specific disorder.

Q. Okay. At the bottom of page eight, she begins, second to last paragraph, discussion of the Somatization Disorder, Severe diagnosis made by Dr. Hartings, --

A. Yes.

Q. -- and she suggests that according to the DSM this is a rare condition occurring in only 0.2% of men, and tends to persist across many years of life. Do you agree with her assessment?

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A. Without the DSM in front of me I don't know what the percentage is, but it's, you know, --

Q. It's rare?

A. It's relatively rare, yeah.

Q. Okay. She suggests that the DSM criteria on this diagnosis or disorder is that the complaints span several years and begin before the age of 30. Is that consistent with your understanding?

A. It's probably what it says in there, yeah.

Q. She says most commonly, this disorder is evident by adolescence.

Do you agree with that assessment?

A. Yeah, I don't have it in front of me to understand it well enough to remember the exact onset of somatization disorder.

Q. Based on your twenty-plus year history in the field, would you agree that these type -- this type of disorder is generally evident by adolescence?

A. I really don't know.

Q. Okay. She then says, bottom of page eight carrying over to nine, quote, I see no evidence in the medical records or in data from Dr. Hartings'

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clinical interview with Mr. Jeffries to suggest that Mr. Jeffries has a history of physical complaints prior to age 30 or prior to the time he received the immunizations that he claims led to his current illness.

Do you know if Dr. Hartings explored Mr. Jeffries' medical history prior to age 30 and what he uncovered, if anything?

A. I didn't see any suggestion that he had read his medical records prior to age 30, and frankly nor have I seen those in any of the data that I've looked through.

Q. Did Dr. Hartings inquire during his interview with Mr. Jeffries what his medical history was prior to age 30?

A. I believe he did. I'd have to refresh my memory by specifically looking at it. Would you like me to look at it?

Q. If you desire. But then let me ask you a second question while you are undertaking that effort it requires you to do that.

Based on the history that Dr. Hartings gleaned about Mr. Jeffries' health prior to the age of 30, is it consistent with that someone evidence

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by adolescence somatization disorder?
A. I've not seen anything anywhere in the report to suggest that Mr. Jeffries had a history of excessive doctor involvement --
Q. Okay.
A. -- prior to the time that the records I saw began.
Q. Okay. There's not even the suggestion that Dr. Hartings even made that inquiry; correct?
A. Actually, he did, because he says on page three of his report that Mr. Jeffries denied any prior history of serious illness, hospitalization, or surgery. So he apparently did make the inquiry at least on a basic, you know, have you ever been ill seriously before.
Q. Okay. So the information generated from that inquiry would be inconsistent with the requirement that someone evidence somatization disorder during their adolescence?
A. Yes.
Q. Okay. She then, Dr. Shear on page nine, first paragraph, full paragraph, starts with the word all of the following material must be met.
And I understand you disagree with her

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about the mandatory nature of criteria, and you highlighted earlier based on review of her report that there is no evidence of any sexual symptom in the records; is that correct?
A. Yes.
Q. In fact, did Dr. Hartings even inquire about the sexual -- Mr. Jeffries' sexual capabilities?
A. I believe he did.
Q. And what was the evidence that he generated?
A. I believe it was in his report that he asked something about the effect this had on the relationship, and Mr. Jeffries commented that he and his wife -- his wife had really been a great support to him and stuck through this and that they continued to have a sexual life and that that was unaffected.
Q. And the next paragraph in the continuing discussion of the diagnoses of somatization disorder, Dr. Shear says either each of the symptoms above can't be explained fully by a known medical condition or else there is an established medical condition but the physical complaints are in excess

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of what is expected. Do you see that?
A. Yes.
Q. Do you agree with her assessment that that is one of the alternative requirements?
A. Yes.
Q. Do you agree with her last -- the last sentence she has in that paragraph, therefore, it is at least plausible to consider as a possibility that his symptoms are fully explained by known medical condition?
A. No. That's the part I do quarrel with.
Q. Okay. Why do you quarrel with that?
A. I should say this with a caveat that I'm not a physician. My understanding from the reading of the medical file is that there has been no definitive medical diagnosis reached in this case.
Q. So because it's your understanding that there is no medical doctor that has diagnosed Mr. Jeffries with chronic fatigue syndrome or any other medical condition, autoimmune disorder, your data is that that doesn't exist so it must be a psychological disorder?
MR. ELLIS: Objection. Form.
A. No, that's mischaracterizing my

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testimony. What I'm saying is if you read the beginning of the paragraph it says either each of the symptoms above cannot be explained fully by a known medical condition or else there is an established medical condition but the physical complaints are in excess of what you would expect.
So, the fact that there is no known medical condition here, obviously those symptoms cannot be explained fully by it because there's no, you know, true diagnosis reached. I mean if someone's limping and you say, ha-ha, this person's exaggerating, and it turns out they have a fractured leg, that is an example of where the fracture would explain the known limping. Or if you think, and again this is somewhat suggestive, that they are limping more than you would limp if they had a fractured leg, then that would also meet the criteria that is excessive response to that condition. That leaves open the possibility that there is an unknown malignancy in the leg that no one's yet seen that causes it to be much worse than the pain that most other people would have if they fractured their leg. On the other hand, we are talking about known medical conditions here, and

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that is the point that I make here, that is not a known medical condition.
Q. As far as you know?
A. As far as I have seen in the record, yeah.
Q. Have you reviewed Dr. Pretoris' -- P-R-E-T-O-R-I-S, report?
A. I would have to be shown it to see if I remember it, frankly, there were so many medical doctors involved here.
Q. Her last -- her next paragraph she suggests that the clinicians who have seen Mr. Jeffries are consistent in stating that they do not believe he is consciously fabricating his symptoms. Do you agree with that?
A. They have, in fact, been consistent in that, yes.
Q. She starts a discussion of Dr. Hartings' obsessive-compulsive personality disorder diagnosis at the bottom of page nine. Do you see that?
A. Yes.
Q. And then on the top of page ten that paragraph continues. In the fourth line at the end of the line there is a sentence that starts with the word by. Dr. Shear says by definition, personality

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disorders must have an onset by at least adolescence or early adulthood and must affect multiple areas of functioning. Do agree with that?
A. Yes.
Q. She says it's not possible to abruptly develop a personality disorder at Mr. Jeffries' age unless it's the direct result of a medical illness in which case a different diagnosis is given or to have it effect only his search for medical treatment without impacting other aspects of his life. Do you agree with that?
A. In a narrow context of this being a personality disorder, yes, I do.
Q. Okay. In the next paragraph, second sentence, third line, she says that she was unable to find any evidence at all in Mr. Jeffries' record that he has longstanding symptoms of a personality disorder. Were you able to find that in the record?
A. I didn't see that.
Q. She says people with OCPD -- and that is obsessive-compulsive personality disorder -- have extreme difficulty with their interpersonal relationships, including marital relationships, interactions with their children, tending to be

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highly controlling, coworkers and supervisees, highly perfectionistic and unable to delegate, and supervisors, so concerned about doing each task perfectly that it's hard to prioritize, hard to complete things successfully, and deadlines are very commonly missed. Is that accurate with your understanding of the disorder?
A. Yes.
Q. She says from the material in the file, I see no evidence that Mr. Jeffries had any of these difficulties at work before this illness, nor that he had impairment in other aspects of his life prior to his illness.
And I think when she refers to illness she is talking about the '97, '98 time frame. From your review of the file were you able to glean any evidence that Mr. Jeffries had any difficulties in his work or marital life that could be the result of obsessive-compulsive personality disorder prior to 1997?
A. No.
Q. The balance of page 10 she says that according to the DSM IV a person must show four of the following criteria.

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And I know you disagree with her about the mandatory nature.
At the very bottom of page 10, the last two lines she says that she sees no evidence in the record that Dr. Hartings asked questions in his interview about situations in which rigid organization may have been evident. Do you know if Dr. Hartings made those inquiries?
A. No, I don't know.
Q. Have you spoken to Dr. Hartings?
A. No.
(A break was taken)
Q. (by Mr. Roberts) On page 11, I think that's where we were.
A. We were still at the bottom of page 10, but we'll move along.
Q. Okay. Thank you. There's a number of paragraphs there discussing different elements of an obsessive-compulsive disorder diagnosis, and with each discussion of the element Dr. Shear essentially concludes that she doesn't see any evidence that D Hartings even asked about those types of issues.
Is your recollection of Dr. Hartings, the scope of his examination different than what Dr.

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Q. Is that a psychiatric diagnosis?
A. It's in the DSM IV.
Q. Okay. The 294.9?
A. Yes.
Q. Okay. But he concludes that it's likely due to cerebritis as a result of vaccine induced auto immune disorder; right?
A. That's what he says there, yes.
Q. Okay. Would the obsessive-compulsive or somatization disorder be Axis I?
A. No, that would be on Axis II.
Q. Okay. And his Axis II diagnosis of page nine is V71.09, no diagnosis. What does that mean?
A. I think the V codes are codes that are used for things that don't have sort of -- they are sort of like wastebasket categories. Marital disfunction is a V code. Job problems, V code. Social difficulty would be a V code. And my guess, without looking it up, is that this V code is the one that you reserve for no diagnosis, sort of a place keeper. He could have just as easily put down just as easily no diagnosis, which is what I do.
Q. He would have charged me less. Dr. Hawkins says on page eight, the top paragraph,

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middle of the top paragraph there it says on examination Mr. Jeffries' mood was appropriate to his medical condition, i.e. frustrated and unhappy. There is no evidence for acute depression, obsessions, or compulsions. He was concerned about a serious illness that had been going on for several years and was investigating every possibility. This appears to be appropriate behavior for a bright executive who's experiencing a debilitating medical illness.

Have you ever had the opportunity to personally sit with Mr. Jeffries and examine him and make the assessment that Dr. Hawkins did on his personal exam?
A. No.
Q. Dr. Hawkins then says on my second examination two years later in June 2003, Mr. Jeffries continues to be frustrated by his illness which is characterized by waxing and waning symptoms.

And according to Dr. Hawkins, Mr. Jeffries appeared more disorganized with more deterioration in his short-term memory.

You didn't have the occasion to examine

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Mr. Jeffries two years apart and come to a similar conclusion or refute that, did you?
A. No.
Q. The next paragraph he says on neither examination did I note evidence of depression such as tearfulness, sad affect, social withdrawal, or suicidal thoughts. On neither exam did I obtain any clinical history that would be -- that would support a diagnosis of a Personality Disorder. Mr. Jeffries has never exhibited any pervasive patterns of maladaptive behavior during his adult life, criteria that are necessary for diagnosis of any Personality Disorder.

You would agree based on what you know about Mr. Jeffries' life prior to 1998 that Dr. Hawkins' assessment there is correct?
A. That's not what Dr. Hawkins is saying there.
Q. He says during neither of his exams --
A. Right. Which have both been subsequent to 1998.
Q. Right. But I thought we were in agreement that the obsessive-compulsive personality disorder is something that needs to exhibit itself in

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adolescence, and some disorder needs to exhibit itself before age 30?
A. Well, I wouldn't say we were in agreement about that. I would agree that you said that is what your expert said, and I said I don't necessarily see it that way.
Q. Okay.
A. But despite that, that is not what he is saying in this paragraph. What he is saying in this paragraph is based on his observations he didn't see anything maladaptive going on in either of the two examinations that he had with him, both subsequent to 1998.
Q. Okay. Fair enough.
A. He hadn't seen him before then either.
Q. Okay. He also says he didn't obtain any clinical history that would support such a diagnosis; right?
A. That's what he says there, yes.
Q. Okay. Are you aware of any clinical history prior to 1998 that would support such diagnoses?
A. No.
Q. I'm going to be forty in three weeks.

Assuming I don't have obsessive-compulsive disorder sitting here today or somatization disorder, am I someone that can develop those personality traits now or in the future?

A. Yes.

Q. Okay.

A. Even though you wouldn't meet the criteria diagnosis based on the onset being before age 40 unless you really hurried.

Q. Before age 40?

A. No, it's actually age 30 what is in there.

Q. Now, you are making that suggestion just on the basis of my assumption that you've not gleaned me to have any of those presently?

A. Well, I've not examined you clinically, so I don't know.

MR. ELLIS: I can suggest some.

Q. (by Mr. Roberts) The last paragraph of page eight says that, according to Dr. Hawkins, there's been a SPECT scan performed on Mr. Jeffries. S-P-E-C-T. Do you know what a SPECT scan is?

A. Generally, yes.

Q. And according to Dr. Hawkins, the SPECT scan was consistent with nonspecific neurodegeneration, likely immune mediated cerebritis because of changes in the posterior fossa. F-O-S-S-A. The SPECT scan demonstrated adequate cerebral vascular flow and no evidence of an affective disorder. You have no basis to comment one way or the other about these conclusions there, do you?

A. The only basis I have is as recently as last week in another issue reading a review of where the American Academy of Neurology views the value of SPECT scanning, and according to this article which was published just -- in fact, it was in the most recent "Journal" of, I think, the "Archives of Clinical Neuropsychology" they went through this, five categories that the American College of Neurology uses to determine whether something is an established technique, a promising technique, an investigational technique, a doubtful technique, or an unproven technique. Those are the five strata that they have. SPECT scanning in the area of at least cognitive disorders and coming from a background in terms of concussion-kinds of cognitive

disorders was found to be an investigational technique as late as 1996 when apparently they promulgated these levels. Investigational meaning it wasn't proven and it wasn't established yet. It wasn't at that level of scientific value but nonetheless produced some information that could potentially be of help in terms of understanding what's going on with someone. I found that to be interesting because I know that from a clinical point of view people are often looking for SPECT scans as ways of trying to raise hypotheses about what is going on, but I don't know anyone that is using that as a conclusive technique or anyone that is ruling out something like an affective disorder based on anything in the SPECT scan literature that's currently accepted.

Q. Okay. What was that journal?

A. That was "Archives of Clinical Neuropsychology", the article.

Q. September 2003?

A. I may even have it in my bag. I carry a lot of junk here. Actually, it's Volume 18, No. 6, August 2003. Page 591.

Q. Great.

A. And they also talk about the Society of Nuclear Brain Imaging Council's position that there was not yet adequate evidence to support the use of SPECT or PET scanning in mild traumatic brain injury to establish cause and effect relationships. So certainly an interesting kind of thing it adds to the total picture of what we understand about someone.

Q. Was it the same for PET scan, is that what you just said?

A. Yes.

Q. Okay. Do you know who Dr. Frye is?

A. No.

Q. That concludes paragraph eight. Paragraph nine, the top we talked about a little bit Axis I, and Axis II. What are Axes III, IV and V?

MR. ELLIS: I'm sorry, page nine, you mean?

MR. ROBERTS: Page nine.

MR. ELLIS: Thank you.

A. Axis III is the place used for listing medical conditions. So anything that is medically related, history of cancer, history of hypertension, goes in Axis III, especially if the evaluator

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thought it was relevant to the Axis I or Axis II conditions.
Q. What was Axis II related to?
A. Personality disorders.
Q. Axis IV?
A. Axis IV is stressors, current levels of stress on the person's life, what are the things you see. Sometimes people will have a disorder where it's exacerbated by financial distress or loss of loved one or loss of job. Axis V is the global assessment of functioning. It's a 100 point scale with some anchors at different levels along the way with lower scores reflecting greater, greater impairment in functioning and higher scores reflecting higher levels of functioning. And, you know, if you want to do a full comprehensive multiaxial diagnosis, you try to estimate what the person's current level is and what their best level of functioning has been in the past year.
Q. Are there different descriptions for different bands?
A. Yes, there are.
Q. What would 60 be?
A. 60 is, it's, to the best of my

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recollection in the mild to moderate level of impairment. The person's still functioning and in routine everyday situations.
Q. When was the last time you spoke to Jeff Champagne about Mr. Jeffries?
A. Not in the recent past. About Mr. Jeffries? I can't remember. It's been a while.
Q. Have you spoken to anyone at DMS about Mr. Jeffries in the past six months?
A. When did I do my last review? May 5th, yes. So I must have spoken with him or with somebody down here just prior to that when they asked me to take a look at the new data coming through. John Graff sent me a letter on March 20th, and I'm not sure if I spoke with him on the phone or didn't about it.
Q. You don't know if you spoke to him on the phone both prior to your examination or post-report?
A. I don't know if I spoke with him on the phone at any point along. I may have just taken in the letter and the report and written a response to it.
Q. So you can't recall speaking to anyone at

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DMS about your report --
A. Correct.
Q. -- orally? So I understand, you agree with Dr. Hartings' diagnosis about the personality disorders of Mr. Jeffries; is that right?
A. I agree that Mr. Jeffries has a -- is likely has a somatoform disorder.
Q. Likely has?
A. Yeah. I mean we are all talking about more likely than not, okay, these are not things that exist in real life. Disorders are conceptual constraints.
Q. So it's your opinion it's more likely than not that he suffers somatization personality disorder?
A. Yes.
Q. Okay. And there are obsessional tendencies involved in this?
A. I don't believe that he has a diagnosis of obsessive-compulsive disorder.
Q. It's not your opinion that it's more likely than not that he suffers from the DSM IV defined obsessive-compulsive personality disorder?
A. Correct.

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Q. And what do you base your judgment with regard to that diagnosis on?
A. Which one?
Q. The obsessive-compulsive?
A. The very focused and specific kind of way in which he responds to some of the test materials, and the symptom presentation has that flavor to it, that -- this is, I mean, again, this is not a diagnosis, this is based on, you know, we all have personality traits and personality approaches to things. And I think that there is an obsessional way in which he has approached the work-up of this medical condition.
Q. No, but my question was it's not your opinion that he has OCPD, and why do you conclude that he doesn't have OCPD?
A. Oh, I don't see the range of obsessive kinds of behaviors or compulsive thoughts and impairment based on that in terms of his relationships. I mean I think Dr. Shear was correct in that portion of her analysis.
Q. Are most people that enjoy success, lawyers, doctors, psychologists, to a certain degree obsessive or compulsive? I mean those words, are

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they misused by the lay people?
A. It's like all aspects of normality that, you know, in moderation it's probably a good thing for success to be more obsessive and compulsive about things, because you make sure you get it done and you don't forget your socks and stuff like that. But, you know, in excess, it gets in the way of relationships that people spend so much time counting their socks before they leave home that they don't get to the plane on time because --
Q. Fair enough.
A. Because they are just straightening them all out and color matching them and making sure they have exactly the right sizes.
Q. Get the flags on the outside. Both Dr. Shear and Dr. Hawkins say that in the five or six years that Mr. Jeffries has been dealing with his illness the manner in which he has approached treatment is normal. Would you disagree with that?
A. I would.
Q. Okay. Why?
A. I can tell you that the sheer number of medical evaluations and specialists sought to try to understand or reach a diagnosis in this case is

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clearly in the top one percent of all cases I've seen over my career, and it is possibly the greatest number of opinions that any one individual has ever sought to try to establish a diagnosis.
Q. You know, there are people that I know that live in Cincinnati that have never been to Kentucky, and I bet there's people here that live in Springfield that have never been to Connecticut. So Mr. Jeffries you understand had a very successful career, made a lot of money and traveled around the world for his job. So are you comparing apples to apples when you talk about how far someone will travel to see a doctor?
MR. ELLIS: Objection to form. You can go ahead.
Q. (by Mr. Roberts) Go ahead.
A. I am not concerned about the distances. I realize he got his Master's degree at Cambridge, I realize he is a world traveler, and as an investment banker he was all over the place. Identifying who are the top experts in a particular given area and seeking out appropriate medical opinions from them I don't quarrel with. I think that is a reasonable thing to do. This is a couple notches above that in

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my viewpoint.
Q. Because of the numerosity of doctors?
A. That, and also the other, the other characteristic that's so unusual about this case is the vividness and the quality and the number of complaints that -- I mean you want to look back, look at Dr. Bastien's evaluation, that is the one that probably goes into the greatest degree of specificity where there is a virtual shopping list of complaints involving multiple areas of the body and very striking kinds of complaints that I believe are significantly greater than what is normal. When I use that term, for medically ill people to have -- not that I think he could not have a medical illness, but that even if he had a medical illness, and he may, in fact, have one, over top of that there is a level of focus and obsession, if you will, and somatic preoccupation with this that is far greater than what you see going through the average hospitals in most places.
Q. Okay. What other physicians or psychologists have you spoken to regarding Mr. Jeffries?
A. None.

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Q. Do you know that you've been identified as an expert in the case formally on behalf of DMS?
A. I would assume so or else you probably wouldn't be deposing me. Not that this hasn't been fun.
Q. I love your eagerness. Okay. Doctor, we're concluded to the extent that there's no further opinions that you come to develop between now and trial, in which case I'd like the opportunity to explore those. But we are concluded for now. Thank you.

(The deposition was concluded)

SIGNATURE/ERRATA SHEET

I have read the foregoing, and it is a true transcript of the testimony given by me at the taking of the subject examination with the following corrections/changes, if any:

_____ _____

date MITCHELL I. CLIONSKY, Ph.D.

PAGE	LINE	CHANGE	REASON

Eric Jeffries v. Centre Life Insurance Co., et als.
Date Taken: September 23, 2003
jrs

COMMONWEALTH OF MASSACHUSETTS

Hampden, ss.

I, JESSICA R. STASIO, a Notary Public in and for the Commonwealth of Massachusetts, do certify that pursuant to notice there came before me on the 23rd day of September, 2003, at the offices of ACCURATE COURT REPORTING, 1500 Main Street, Springfield, Massachusetts, the following named person, to wit: MITCHELL I. CLIONSKY, who was by me duly sworn to testify to the truth and nothing but the truth as to his knowledge touching and concerning the matters in controversy in this cause; that he was thereupon examined upon his oath and said examination reduced to writing by me; and that the deposition is a true record of the testimony given by the witness, to the best of my knowledge and ability.

I further certify that I am not a relative or employee of counsel or attorney for any of the parties nor a relative or employee of such parties, nor am I financially interested in the outcome of the action.

WITNESS MY HAND, this 15th day of October, 2003.

_____
Jessica R. Stasio

My Commission expires:
March 15, 2007